Washington State Health Care Authority

Medicaid Provider Guide

Mental Health Services

(WAC 182-531-1400)

January 1, 2014

A Billing Instruction

About this guide

This publication, by the Health Care Authority (agency), supersedes all previous *Mental Health Services for Children, Psychiatric and Psychological Services Medicaid Provider Guides* published by the agency.

Note: The underlined words and phrases are links in this guide. Some are internal, taking you to a different place within the document, and some are external to the guide, leading you to information on other websites.

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-98 Changes to federal law	January 1, 2014	All	Restructured entire document
		All	New policies incorporated throughout to achieve mental health parity in mental health benefits

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Resources

Topic	Resources
Obtaining prior authorization or a limitation extension	For all requests for prior authorization or limitation extension, submit: • A completed, typed General Information for Authorization form, HCA 13-835. This request form must be the initial page when you submit your request. • A completed Fax/Written Request Basic Information form, HCA 13-756, and all the documentation listed on this form and any other medical justification. Fax your request to: 866-668-1214.
Obtaining Medicaid forms	See Medicaid Forms.
Definitions and Abbreviations	See the agency's Medical Assistance Glossary.
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page.
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic or paper billing	
Finding Medicaid provider guides, provider notices, fee schedules, and other agency documents	
Third-party liability other than agency managed care	

Program Overview

(WAC 182-531-1400)

This document describes the set of benefits managed by the Health Care Authority (agency) and available to those clients who do not meet the regional support network (RSN) access to care standards (ACS) and who are therefore not receiving care through the RSN community mental health clinic. Providers must transfer clients who meet the ACS to an RSN for care. More information about RSNs is available from the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery.

What services are covered?

The agency covers the following:

- Mental health services for all clients
- Mental health services from psychologists, licensed mental health counselors, independent clinical social workers, advanced social workers, and marriage and family therapists
- Psychiatric services by psychiatrists and psychiatric advanced registered nurse practioners (P-ARNPs) for all clients
- Psychological testing by psychologists for all clients

Additional mental-health related services

The following covered services are explained in other agency billing instructions:

- Applied behavior analysis services
  (See WSR 14-02-056)
- Alcohol or substance misuse counseling (SBIRT)
  (See the Physician-Related Services Medicaid Provider Guide)
- Tobacco cessation counseling
  (See the Physician-Related Services Medicaid Provider Guide)

How are services administered?

Mental health services are available through:

Professionals with individual Core Provider Agreements who will accept payment on a fee-for-service (FFS) basis for providing services to individuals not enrolled with a managed care organization (MCO) and whose condition does not meet the RSN access to care standards.

- Managed Care Organizations (MCOs) which are under contract with the agency's Division of Health Care Services' Apple Health Managed Care program to provide health care services for individuals whose condition does not meet the RSN Access to Care Standards and who are enrolled in and receiving care from an MCO.

- Regional Support Networks (RSNs), which are under contract with the Department of Social and Health Services' Division of Behavioral Health and Recovery, serve individuals whose condition meets the RSN Access to Care Standards. A memorandum of understanding between DSHS and the single State Medicaid Agency (the Health Care Authority) allows DSHS to contract with RSNs.

Who may provide mental health services?

The following licensed mental health professionals may bill the agency for mental health services on a fee-for-service basis:

- Psychiatrists
- Psychologists
- Advanced registered nurse practitioners (ARNPs)
- Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
- Independent clinical social workers or licensed advanced social workers
- Mental health counselor
- Marriage and family therapists

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY).
3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are managed care enrollees eligible?

Yes. Managed care organization (MCO) enrollees are eligible for mental health services. When verifying eligibility for mental health services using ProviderOne, if the client is enrolled in an agency MCO, managed care enrollment will be displayed on the client benefit inquiry screen. All services for MCO enrollees must be requested directly through the MCO enrollee's primary care provider. (See WAC 182-538-060 and 182-531-0950.)

All mental health services covered under an MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

-
- Payment of covered services.

- Payment of services referred by a provider participating with the MCO to an outside provider.

Provider Eligibility

How do I enroll to provide mental health services?

To enroll you must:

- Obtain a national provider identifier (NPI) from the federal government.
- Complete a core provider agreement.
- Send all of the above to Provider Enrollment. For more information, contact Provider Enrollment (see Resources Available web page).

To provide services to children, all providers except psychologists and psychiatrists must:

- Write and sign a letter attesting to a minimum of two years' experience in providing mental health services to children, youth, and their families as described in this guide (the letter does not need to be notarized). If you are already an enrolled provider, you must send in this additional information to bill for these services.

Who is eligible to provide mental health services?

To be eligible to provide and bill the agency fee-for-service for mental health services, all mental health professionals must:

- Be licensed by the Department of Health.
- Be in good standing without restriction.
- Have a minimum of two years' experience in the diagnosis and treatment of children, youth, and their families. The experience may be a combination of pre- and post-licensure and may include supervised internships completed as part of a master's degree curriculum. The equivalent of one year of full-time experience must be under the supervision of a mental health professional trained in child and family mental health.

The exemptions to the minimum experience requirement are licensed psychologists and licensed psychiatrists.

Coverage

The agency covers medically necessary psychotherapy, including therapy services and family therapy visits, using the following CPT codes. Additional coverage, services, and codes are discussed in separate sections of this guide, which are organized by provider type. All providers must comply with the documentation requirements in WAC 388-865-0610.

Eligible providers who are approved to provide mental health services may bill one psychiatric or psychological service per day, per client, which includes the evaluation and management service.

Note: Due to its licensing agreement with the American Medical Association, the agency publishes only the official, short CPT® code descriptions. To view the full descriptions, please refer to a current CPT book.

Mental Health Services Coverage Table

CPT Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA	Hours
+90785**	Psytx complex interactive	X	X	X	X			1.00
90791***	Psych diagnostic evaluation	X	X	X	X	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year		1.00
90792***	Psych diag eval w/med srvcs	X	X			One psychiatric diagnostic interview exam allowed per client,		1.00

Mental Health Services Coverage Table

CPT Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA	Hours
						per provider, per calendar year		
90832	Psytx pt&/family 30 minutes	X	X	X	X			0.50
+90833**	Psytx pt&/fam w/e&m 30 min	X	X					0.50
90834	Psytx pt&/family 45 minutes	X	X	X	X			1.00
+90836**	Psytx pt&/fam w/e&m 45 min	X	X					1.00
90837	Psytx pt&/family 60 minutes	X	X	X	X			1.00
+90838**	Psytx pt&/fam w/e&m 60 min	X	X					1.00
90845	Psychoanalysis	X						
90846	Family psytx w/o patient	X	X	X	X			
90847	Family psytx w/patient	X	X	X	X			1.00
90849	Multiple family group psytx	X	X	X	X			

Mental Health Services Coverage Table

CPT Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA	Hours
90853	Group psychotherapy	X	X	X	X			1.00
90865	Narcosynthesis	X						
90870	Electroconvulsive therapy	X						
96101	Psycho testing by psych/phys				X	See Psych-ological Assess-ment and testing	Limit of two. PA if over limit of two for outpatient only	
96101 UC							EPA# 870001315	
96110	Developmental screen				X			
96111	Developmental test extend				X			
96116	Neurobehavioral status exam				X		PA	
96118	Neuropsych tst by psych/phys				X	EPA, PA if EPA does not apply	EPA#: 870001207	
96119	Neuropsych testing by tech				X	EPA, PA if EPA does not apply	EPA#: 870001207	
M0064	Visit for drug	X	X			Not allowed in		

Mental Health Services Coverage Table								
CPT Code	**Short Description**	**Psych MD**	**P-ARNP PMHNP-BC**	**LMHP***	**Psych Ph.D.**	**Limits**	**EPA/PA**	**Hours**
	monitoring					POS 21		
*Includes Social Worker, Marriage and Family Therapists and Mental Health Professionals								
**Use add-on codes with an appropriate CPT code (see CPT book for guidance)								
***A psychiatric diagnostic interview exam (CPT code 90791 or 90792) and a psychological evaluation (CPT code 96101) cannot be billed on the same day, without prior authorization.								

Where can I view the fee schedules?

See the following fee schedules for more information:

- Psychology fee schedule
- Mental health fee schedule
- Physician-related services fee schedule

Services

What services can psychiatrists, P-ARNPs and PMHNP-BCs provide?

For a comprehensive list of the services psychiatrists, psychiatric ARNPs (P-ARNPs), and psychiatric mental health nurse practitioners-board certified (PMHNP-BCs) can provide, see the mental health services coverage table and the table below.

Inpatient Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Outpatient Covered Procedure	**CPT Codes**
Emergency department visits	99281-99288
Observation	99218-99226, 99234-99239
Consultation	99241-99245
Office Covered Procedure	**CPT Codes**
Office visits	99201-99215
Consultation	99241-99245
Other Covered Procedure	**CPT Codes**
Case Management Service • Team Conferences • Telephone Calls	99367, 99441-99443
Domiciliary home or custodial care services	99324-99340
Home services	99341-99359
Nursing facility services	99304-99318

- The agency covers these outpatient services to treat conditions that fall within the ICD-9CM diagnosis codes 290-319, as well as for preventive care, represented by V ICD9 diagnoses codes. See the table below.

Diagnosis Code	Description
V110	Hx of schizophrenia
V111	Hx of affective disorder
V112	Hx of neurosis
V113	Hx of alcoholism
V114	Hx combat/stress reactn
V118	Hx-mental disorder NEC
V119	Hx-mental disorder NOS
V1541	History of physical abuse
V1542	History of emotional abuse
V1549	Psychological trauma other
V402	Other mental problems
V4031	Wandering in diseases classified elsewhere
V4039	Other specified behavioral problem
V6120	Counsiling for Parent-child problems unspecified
V6121	Cousiling for victum child abuse
V6122	Cousiling for perpetrator of parental child abuse
V6123	Counsiling for Parent-biological child problem
V6124	Counsiling for Parent-adopted child problem
V6125	Counsiling for Parent (gardian)-foster child problem
V6129	Other parent-child problem
V6281	Interpersonal probl NEC
V6282	Bereavement, uncomplicat
V6283	Cnsl perp phys/sex abuse
V6284	Suicidal ideation
V6285	Homicidal ideation
V6289	Psychological stress NEC
V629	Unspecified psychosocial circumstance
V790	Screening for depression
V791	Screening for alcoholism
V792	Scrn intellect disabilty
V793	Screen-development prob
V798	Screen-mental dis NEC
V799	Screen-mental dis NOS

- When performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate E&M code and the appropriate psychiatric add-on CPT code (e.g., CPT® code +90833).
- The agency does not cover psychiatric sleep therapy.
- The agency does not pay for HCPCS code M0064 in an inpatient setting (place of service 21).
- Claims for inpatient rounds must be charged using one of the CPT® codes in this section.

Services delivered in an inpatient setting

Note: All admissions for acute, community psychiatric inpatient care require prior authorization (PA) from the designated Division of Behavioral Health and Recovery (DBHR) designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the PA from the DBHR designee. See the list of RSNs at DBHR's RSN web site.

The agency covers professional inpatient mental health services when provided by a psychiatrist, psychiatric advanced registered nurse practitioner (P-ARNP), or psychiatric mental health nurse practitioner-board certified (PMHNP-BC) as follows:

- One hospital call per day for direct psychiatric client care. The agency pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. The agency considers services rendered during rounds to be direct client care services and may include up to one hour individual psychotherapy, family/group therapy, and electroconvulsive therapy.
- One electroconvulsive therapy or nacrosynthesis per client, per day when performed by a psychiatrist only.

Involuntarily admitted clients

For Involuntary Treatment Act (ITA) admissions under Chapters 71.34 and 71.05 RCW, the agency covers the inpatient mental health services delivered by physicians and ARNPs. For all clients involuntarily detained under Chapters 71.34 and 71.05 RCW, physicians and psychiatric Advanced Registered Nursing Practitioners (P-ARNPs) may bill the agency for psychiatric services under the ITA according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or P-ARNP within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90791 or 90792.

- A day's rounds, along with any one of the following, constitute direct client care:

  - ✓ Narcosynthesis
  - ✓ Brief (up to one hour) individual psychotherapy
  - ✓ Multiple/family group therapy
  - ✓ Group therapy
  - ✓ Electroconvulsive therapy

- A court may request another physician or P-ARNP evaluation.

- The agency pays for physician or P-ARNP evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

- The agency covers psychologist services only for provision of a psychological evaluation of detained clients.

- Out-of-state hospitals must obtain authorization from the appropriate DBHR designee for all Medicaid clients. Neither the agency nor DBHR pays for inpatient services for non-Medicaid clients if provided outside of the State of Washington. An exception is for clients who are qualified for the fee-for-service Medical Care Services (MCS) program. For these clients, the agency and DBHR pay for inpatient psychiatric services provided in bordering cities and critical access border hospitals. All claims for admissions to out-of-state hospitals are paid as voluntary legal status as the ITA applies only within the borders of Washington State.

  Additional costs for court testimony are paid from the county ITA administrative fund.

Note: For general information about admissions under the Involuntary Treatment Act (ITA), see Involuntary Treatment Act admissions.

Outpatient psychiatric services and limitations

See the mental health services coverage table for covered mental health services. Outpatient psychiatric services are subject to the following limitation: the agency pays for only one psychiatric diagnostic interview exam (90791 or 90792) per client, per provider, per calendar year.

Drug monitoring

Drug monitoring refers to a brief office visit for the sole purpose of monitoring or changing drug prescriptions. Drug monitoring (HCPCS code M0064) is used in the treatment of mental psychoneurotic and personality disorders. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a drug monitoring visit is the use of medication for relief of the client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that require discussion beyond minimal psychotherapy, the focus of the service is broader and is considered psychotherapy rather than drug monitoring.

Drug Monitoring:

- May be billed as one psychiatric medication management service per client, per day, in an outpatient setting when performed by one of the following:

  - ✓ Psychiatrist
  - ✓ P-ARNP
  - ✓ PMHNP-BC

- May be billed when prescribing medication and when reviewing the effects of the prescribed medication.

- Is intended for use for clients who are being managed primarily by psychotropic medications.

- Must be provided during a face-to-face visit with the client, unless it is part of a qualified telemedicine visit.

- Is not allowed in POS 21.

Documentation requirements for drug monitoring

The medical record must be clear, concise, and complete. A check list by itself is not accepted as complete documentation. The treating provider must document in the medical record that drug monitoring was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated drug monitoring. These requirements are in addition to those in WAC 388-865-0610.

Documentation of medical necessity for drug monitoring must address all of the following information in the client's medical record in legible format:

- Date and time
- Diagnosis – update at least annually
- Interim medication history
- Current symptoms and problems, including any physical symptoms
- Problems, reactions, and side effects, if any, to medications or ECT
- Current mental status exam
- Any medication modifications
- The reasons for medication adjustments/changes or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcomes

Note: When a psychiatrist, P-ARNP, or a PMHNP-BC sees a client for psychiatric care and only drug monitoring is necessary, the practitioner may bill for either drug monitoring or an evaluation and management (E&M) visit for that date of service.

Alternatively, when a psychiatrist, P-ARNP, or a PMHNP-BC provides psychotherapy and drug monitoring, the practitioner may bill an E&M visit and a qualifying psychotherapy service on that date of service.

In accordance with the National Correct Coding Initiative (NCCI), drug monitoring and an E&M or psychotherapy service cannot be billed on the same day of service, by the same provider. For additional information, see NCCI.

Partnership Access Line for prescribing practitioners

The Partnership Access Line (PAL) is a telephone-based child mental health consultation system for Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services.

The PAL team is available to any primary care provider throughout Washington State. Washington's primary care providers are encouraged to call the PAL toll free number 866-599-7257 as often as needed. PAL provides rapid consultation responses during business hours (Monday-Friday, 8:00 a.m. to 5:00 p.m.) for any type of children's mental health issue that arises with any child. See also Primary Care Principles for Child Mental Health, by Robert Hilt, MD, Program Director, Partnership Access Line, Seattle Children's Hospital.

What services can psychologists, including neuropsychologists, provide?

Covered Services

See the mental health services coverage table for covered mental health services. Outpatient psychological services are subject to the following limitation: the agency pays for only one psychiatric diagnostic interview exam (90791) per client, per provider, per calendar year.

The agency covers these services to treat conditions that fall within the ICD-9CM diagnosis codes 290.0-319, as well as for preventive care, V ICD9 diagnoses codes.

The agency pays licensed psychologists for all of the following:

- Psychological assessment
- Developmental testing
- Neuropsychological testing
- Mental health services

Note: Psychologists that provide mental health services for children must be approved to provide mental health services for children.

Psychological assessment and testing

(WAC 388-865-0610)

- Psychological assessments may be done on either an outpatient basis or an inpatient admission. Psychological assessments are not limited to Involuntary ITA admissions.
- Psychological assessments must include a complete diagnostic history, examination, and assessment. Testing cognitive processes, visual motor responses, and abstract abilities is accomplished by combining several testing procedures.
- To receive reimbursement for the testing, the psychologist must keep a report in the client's file that contains all of the components of a psychological assessment including test results and interpretation of results.
- Use CPT code 96101 when billing for psychological testing.
- Outpatient psychological testing is limited to two units of code 96101 without prior authorization (PA) per client, per lifetime.
- If additional outpatient psychological testing is necessary, psychologists must request additional units of CPT code 96101 through the PA process.

Note: Services related to the evaluation using CPT code 96101 done by a center of excellence (COE) for a child suspected of having autism spectrum disorder have the limitation of up to 7 units per lifetime for clients 20 years of age or younger. These evaluations must be billed using UC modifier and EPA #870001315.

Psychological evaluations for clients admitted under ITA

The agency covers, without PA, psychological evaluations (CPT code 96101) for clients admitted to a psychiatric hospital as an involuntary admission in accordance with the ITA, Chapters 71.05 and 71.34 RCW.

When billing for an evaluation under these circumstances, do both of the following:

- Type SCI=I in field 19 on the CMS-1500 claim form or enter SCI=I in the claim note field of the 837P professional E-claim.
- Provide documentation that the client was admitted to an inpatient facility.

Outpatient developmental testing

The agency reimburses for developmental testing (CPT codes 96110 and 96111) when conducted by a psychologist or neuropsychologist.

Outpatient neuropsychological testing

The agency reimburses for neuropsychological testing (CPT codes 96118 and 96119) only when the provider meets the first two requirements or the client meets the third requirement:

- The provider is currently licensed in Washington State to practice psychology or clinical neuropsychology.
- The provider has obtained written/faxed prior authorization from the agency.
- The client meets the expedited prior authorization (EPA) criteria. (See Expedited prior authorization).

A prior authorization (PA) request for neuropsychological testing of children requires a detailed review of the individualized education plan (IEP) outlining all of the following:

- The specific clinical issues in the IEP that have not been sufficiently addressed
- The aspects of the child's rehabilitation that are not improving
- Specific additional benefits that psychological testing will provide the client, describing what the IEP is already addressing, and how the proposed testing will improve the treatment plan
- Other psychological testing that has been done
- Relevant consultations from physiatrists, neurologists, developmental pediatricians, etc.

A PA request for neuropsychological testing of adults and children, who are not in school, requires all of the following information:

- The client's current diagnoses
- If available, a copy of the reports produced by the testing for the agency to review
- For psychological testing that has been done in the past:
    - ✓ Documentation of the provider's review of reports produced by the testing

- ✓ Documentation of the provider's review of the results of the previous testing(s)

- An explanation detailing the essential medical knowledge that is expected to be gained from psychological testing

- Specific details documenting how the results of psychological testing will improve the day-to-day care of this client

Note: The agency no longer requires providers who bill for neuropsychological testing to be board-certified; however, upon request, providers must be able to furnish credentials that demonstrate their expertise.

Neuropsychological Testing	
Note: If the client does not meet the expedited prior authorization (EPA) criteria listed in this guide and this table, the agency requires prior authorization (PA) for the testing.	
Services	Neuropsychological testing of clients 16 years of age and older, in an outpatient or inpatient setting
Providers	The agency pays only "qualified" providers for administering neuropsychological testing to eligible agency clients. To be "qualified," providers must be both of the following: • Currently licensed in Washington State to practice psychology or clinical neuropsychology • One of the following: ✓ Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology ✓ Have adequate education, training, and experience as defined by having completed all of the following: ➢ A doctoral degree in psychology from an accredited university training program ➢ An internship, or its equivalent, in a clinically relevant area of professional psychology ➢ The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences (these two years must include supervision by a clinical neuropsychologist)

Neuropsychological Testing	
Billing Codes	96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.
Billing and Payment Limits	The next section describes 4 groups of criteria that apply to bill in certain circumstances. To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met. For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met. **Group 1** All of the following must be met: • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy. • The patient is 16 years of age or older. • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder. • The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living). • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation. **Group 2** The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following: • Client or family complaints • A head CT (computed tomography scan) • A mental status examination or other medical examination This suspected diagnosis is not confirmed or able to be differentiated from the following:

Neuropsychological Testing	
	• Normal aging • Mild concussion • Depression • Focal neurological impairments A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions. **Group 3** The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help with either of the following: • Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors) **Group 4** The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post-transplant protocol to prevent organ rejection).

What services can LMHPs provide?

Licensed mental health practitioner (LMHP) includes:

- Counselors
- Independent clinical social workers
- Advanced social workers
- Marriage and family therapists

Covered Services

See the mental health services coverage table for covered services provided by the above practitioners. The agency covers these services to treat conditions that fall within the ICD-9CM diagnosis codes 290-319, as well as for preventive care V ICD9 diagnoses codes.

Limitations

Outpatient LMHP services are subject to the following limitations:

- The agency pays for only one psychiatric diagnostic interview exam (CPT code 90791) per client, per provider, per calendar year.
- LMHPs must document client encounters according to WAC 182-502-0020.

How can all providers make sure they have the right place of service?

Since the agency does not limit the total number of outpatient mental health visits, the agency requires the appropriate place of service for mental health services. When the client meets the regional support networks (RSN) access to care standards (ACS), the client must be referred to the RSN for outpatient mental health services. After fifteen visits outside an RSN have been provided, the agency requires written attestation from the provider that the client has been assessed by either the provider or the RSN to determine if the ACS were met and, if they were met, that a timely referral to an RSN for further care has been made. A mental health professional may continue to provide services under this benefit until the RSN can assume the client's care.

Agency-enrolled providers contracted with, or employed by, Community Mental Health Agencies CMHAs must not bill fee-for-service (FFS) and report an RSN encounter on the same service date when providing services to clients eligible for RSN services that meet the ACS. Reportable services for CMHA clients meeting ACS are authorized and purchased separately under the RSN prepaid Inpatient Health Plan.

When is out-of-state care covered?

(WAC 182-501-0182)

Out-of-state mental health care requires prior authorization (PA).

> **Note:** Out-of-state care is not covered for clients covered under the MCS eligibility program.

The agency covers emergency and nonemergency out-of-state health care services provided to eligible Washington State Apple Health clients when the services are:

- Within the scope of the client's health care program.
- Allowed to be provided outside the state of Washington by specific program.
- Medically necessary.

The agency does not cover services provided outside the State of Washington under the ITA (chapter 71.05 RCW and chapter 388-865 WAC), including designated bordering cities.

When the agency pays for covered health care services furnished to an eligible Washington Apple Health client outside the state of Washington, its payment is payment in full according to 42 C.F.R. 447.15.

Prior Authorization

What is prior authorization?

Prior authorization (PA) is the agency or its designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients. When PA is applicable, it is a precondition for provider reimbursement. Expedited prior authorization (EPA) is a form of prior authorization.

Note: EPA does not apply to out-of-state care.

What is the EPA process?

The agency or the agency's designee's EPA process is designed to eliminate the need for written/fax authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling the provider to use the agency's designated "EPA" number when appropriate.

Billing with an EPA number

Enter the EPA number on the billing form in the authorization number field when billing. With HIPAA 5010 implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. When billing multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the paper claim form exactly as follows (not all required fields are represented in the example):

19. Line 1: 870000725/ Line 2: 870000726

When billing only one EPA number on a paper CMS-1500 claim form, list the 9-digit EPA number in field 23 of the claim form. If billing an electronic claim or DDE, add the EPA number at claim level.

When billing multiple authorizations (prior/expedited) numbers on an electronic batch claim (837P) or DDE professional claim, HIPAA 5010 only allows one authorization (prior/expedited) at the claim level. For correct process of the claim, enter the authorization (prior/expedited) for the service to the appropriate service line of the claim.

Note: When the client's situation does not meet published criteria, written prior authorization is necessary.

EPA guidelines

Clinical information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code, or service will be denied.

EPA documentation

The billing provider must document how EPA criteria were met in the client's file and make this information available to the agency or the agency's designee upon request.

Services requiring EPA

Services requiring EPA are noted in this guide as follows:

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
870001207	Neuropsychological Testing	CPT: 96118 and 96119	Refer to Neurological Testing. Up to 15 units for any of these codes combined in a calendar year.
870001315	Psychological Testing	CPT: 96101 UC	Up to 7 hours for clients 20 years of age and younger for whom psychological testing is required to determine a definitive diagnosis for autism spectrum disorder and service is provided at a Center of Excellence. This EPA code is only available to psychologists and psychiatrists. Providers must bill with a UC modifier.

How do I obtain written authorization?

Send your request to the agency's Authorization Services Office (see Resources Available). For more information on requesting authorization, see the agency's ProviderOne Billing and Resource Guide.

Understanding RSNs

What services do RSNs cover?

Crisis services

Crisis mental health services are provided upon request, 24-hours a day, seven days a week, and are available to anyone who needs them regardless of ability to pay. To find telephone numbers for crisis intervention services, see the Regional Support Network RSN Services Information web page.

Community psychiatric inpatient services

RSNs authorize and pay for all medically necessary community psychiatric inpatient services (see WAC 182-550-2600). To refer a client for community psychiatric inpatient services, contact your local RSN.

> **Note:** All inpatient psychiatric admissions, including out-of-state psychiatric hospital admissions, must be approved by the Regional Support Network (RSN).

To find the appropriate RSN and contact information, see the Regional Support Network RSN Services Information web page.

Involuntary Treatment Act (ITA)

For persons 13 years of age and older that are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW, Division of Behavioral Health and Recovery (DBHR) designees authorize payment for services provided to clients receiving medical assistance. When the client is in the process of applying for medical assistance, authorization for payment by the DBHR designee is subject to eligibility determination.

The agency pays for services provided to clients detained under the ITA when the client either refuses to apply for, or does not qualify for any medical assistance program. The agency covers the ancillary charges for physicians, transportation (including ambulance), or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

RSN access to care standards (ACS)

In addition to providing crisis intervention services and community inpatient services, RSNs also manage the public mental health services that are delivered to individuals who are eligible for Medicaid or CHIP and who meet the ACS as determined by:

- Division of Behavioral Health and Recovery (DBHR).
- Licensed and RSN contracted community mental health agencies.

> **Note:** If you are treating or evaluating a client who appears to meet the ACS, contact the local RSN to make a referral for an intake evaluation.

To learn more about the ACS, see the DBHR website.

Billing and Claim Forms

What are the general billing instructions?

Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide. The guide explains how to complete the CMS-1500 Claim Form.

What are the billing instructions specific to this program?

- Providers must bill using the most appropriate procedure code for the total time spent on direct patient care during each visit.
- The agency pays a maximum of one psychiatric service procedure code per client, per day.
- For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.